Maryland Transit Administration (MTA)
Mobility Certification Office
4201 Patterson Avenue, 2nd Floor
Baltimore, MD 21215
Phone: 410-764-8181, Opt. 2
Fax: 410-764-7526

APPLICATION FOR PARTICIPATION IN THE MARYLAND TRANSIT ADMINISTRATION MOBILITY / PARATRANSIT PROGRAM

This information will be used to determine transportation services eligibility and may be shared with other transit service providers. The information will be kept confidential in accordance with State law. Providing false information may constitute a crime punishable by law.

After MTA Mobility receives your completed application form, you will be notified by mail to please call 410-764-8181, Press 2, then 1, Monday through Friday 8:30 a.m. to 4:30 p.m. to schedule an IN-PERSON INTERVIEW.

This IN-PERSON INTERVIEW is a necessary part of the application process. IN-PERSON INTERVIEWS are held at the Mobility Certification Office at 4201 Patterson Ave., 2ND Floor, Baltimore MD 21215. You also may be asked to take a FUNCTIONAL ASSESSMENT at a Concentra office in the Baltimore area.

The application process is complete only when Mobility has received your completed application forms (including health care professional section), when your in-person interview has been performed, and when the functional assessment is complete if you are asked to have one. If you have any questions about the application process, please call the MTA Certification Office at 410-764-8181, press 2, then 1. You can call Monday – Friday, from 8:30 a.m. to 4:30 p.m.

For Office Use

Date Rec'd_____
DC_____ Int Date_____
Temp_____ Perm_____
PCA: Y_____ N_____
Int. C.

I – TO BE FILLED OUT BY THE APPLICANT
PLEASE PRINT CLEARLY. Complete ALL sections.
Incomplete applications will be returned to the applicant.

Section 1 – APPLICANT INFORMATION

_____

First Name Middle Initial Last Name

Address _____ Apt./Unit No. _____

City_____ State _____ Zip Code _____

Telephone: (Home) _____ (Work) _____

(Cell)_____ Male_____ Female_____

E-mail_____ Fax_____

Social Security Number_____-_____-_____ Date of Birth ____/_____/_____

Mailing Address (if different) _____

In case of emergency please contact:

Name_____
First Name Last Name

Address_____

Telephone: (Home) _____ (Work)_____

(Cell)_____

Section 2 – DISABLIITY

Describe your disability and how you believe it limits your ability to use MTA's Local Bus, Metro Subway, or Light Rail services. Please be specific and explain completely.

_____

_____

_____

What is the expected duration of your disability? Permanent ___ Until _____

Section 3 – TRAVEL ASSISTANCE

If you are found eligible for the MTA's Mobility / Paratransit Program, the MTA will use the following information to plan your trip and reserve the proper vehicle for your ride. Check below if you use any of the following:

Cane_____ Manual (standard) wheelchair_____ Crutches_____
Power wheelchair _____ Walker_____ Scooter_____ Oxygen_____
Service animal_____
Other (please describe) _____
If you use a wheelchair, can you transfer to a car with a minimal amount of help?
Yes _____ No_____

For your safety, comfort and convenience, please state the weight of your wheelchair: _____ lbs. Length of wheelchair: _____ in.

Width of wheelchair _____ in. Your weight if over 250 pounds: _____lbs.

Do you need a Personal Care Attendant (PCA) to assist you?

Yes_____ No _____ Sometimes _____

Are you currently certified to use any other Paratransit service, such as Medical Assistance, Social Services, Department of Aging, etc.? Yes_____ No _____ If yes, please list all:

_____

_____

_____

Section 4 – FUNCTIONAL ABILITY

Please answer ALL of the following questions:
Are you physically able to?

1. **Walk or use a wheelchair / scooter, etc. about 1/3 of a city block (200 feet) Without help from another person? Yes_____ No_____ Sometimes_____**

2. **Walk or use a wheelchair / scooter, etc. about three city blocks (1/4 of a mile) Without help from another person? Yes_____ No_____ Sometimes_____**

3. **Climb three 12- inch steps without help? Yes_____ No_____ Sometimes_____**

4. **Wait outside for 15 minutes for the Local Bus, Metro Subway, or Light Rail without help? Yes_____ No_____ Sometimes_____**

5. Travel to and from your home to MTA Local Bus, Metro Subway or Light Rail Service?

Yes_____ No_____ Sometimes_____

6. Travel to and from your trip destination to the MTA Local Bus, Metro Subway or Light Rail Service. Yes_____ No_____ Sometimes_____

7. Get on and off an MTA Lift – Equipped Local Bus without help?

Yes_____ No_____ Sometimes_____

8. Use MTA fixed-route service (Local Bus, Metro Subway or Light Rail) in one direction and Mobility / Paratransit service in the other direction? (Example: travel to dialysis by the Local Bus or Rail, but return using Mobility / Paratransit Service)

Yes_____ No_____ Sometimes_____

Section 5 – VERIFICATION & AUTHORIZATION

I hereby certify, under the penalties of perjury, that the information given above is true and correct. I understand that the MTA will rely upon this information in making a determination as to my eligibility for participation in the program. I agree that if any of the information provided to the MTA is materially false or misleading, the MTA shall have the right to revoke or condition my right to participate in its Mobility / Paratransit Program and pursue any other right or remedy available to the MTA.

I understand that I am required to participate in an in-person interview, and that I may also have to take a functional assessment. I further authorize the release of any personal or medical information to appropriate parties that is necessary in the determination of my eligibility for Mobility / paratransit services.

Signature_____ Date_____ / _____ /_____

Section 6 – APPLICATION ASSISTANCE

If you have completed this application for someone else seeking certification, please provide the following information:

Name_____

Address _____

City_____ State_____ Zip _____ Daytime Phone _____

Signature_____ Date _____/_____/_____

II – THE FOLLOWING SECTION IS TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN OR OTHER HEALTHCARE PROFESSIONAL:

Section 7 – INSTRUCTIONS:

In deciding whether the applicant is eligible for MTA's Mobility / Paratransit Program , the MTA will consider input from the applicant's healthcare provider, in-person interview, and the information provided on the application.

In general, to qualify for the MTA Mobility / Paratransit Program, an individual must have a disability and be unable, as a result of a physical or a mental impairment, to board, ride or exit from any accessible MTA vehicle. The fact that the applicant's medical condition makes using the public transit system more difficult is not a basis for eligibility for the Program. Therefore, focus your response on the functional ability of the applicant. Applicants MAY be referred to a medical facility for a functional assessment as part of the Certification process. If a person is Mobility/ Paratransit eligible for some trips but not others, please specify any such limitations. If an individual has a temporary medical condition, please provide information as to the duration of that medical condition.

Low income is not a factor in determining an applicant's Mobility / Paratransit eligibility.

Please print applicant's name and answer all questions completely using your professional opinion. The healthcare provider must fill out this section, not the applicant.

_____

Applicant's Name (printed)

1. **Does this client have a need for paratransit service, i.e. a curb-to-curb shared ride service that operates within ¾ mile of MTA fixed route services (Local Bus, Light Rail, Metro Subway) and requires reservations 24 hours in advance?**

   Yes_____ No_____ Sometimes_____ If sometimes, please explain:

   _____

   _____

   _____

   _____

2. **Please specify your patient's disabilities (formal diagnosis). Please describe the circumstances in which you feel the applicant would <u>not</u> be functionally able to use the MTA's fixed-route service (Local Bus, Metro Subway, Light Rail):**

   _____

   _____

   _____

   _____

   _____

3. **Can the client, with the assistance of a working wheelchair lift or other boarding assistance device, board, ride, and exit from an MTA Mobility / Paratransit vehicle, i.e. cutaway bus or sedan?**

   Yes_____ No_____

4. **If you believe that the applicant is unable to ride MTA Local Buses, Metro Subway, or Light Rail due to the medical condition(s) noted above, do you expect said condition(s) to be: Permanent_____Temporary_____**

   If temporary, please state the estimated date when the condition is expected to be resolved: _____

5. **Does the applicant's medical condition make it necessary that a Personal Care Attendant (PCA), a person designated by the MTA Mobility client to help meet his or her personal needs while traveling or at their destination, accompany them when using Mobility / Paratransit service?**

   Yes_____ No_____ If yes, please describe why:

   _____

   _____

   _____

I certify that the information I have submitted is my true and accurate medical opinion.

_____

Printed name of physician / healthcare professional

_____ _____

Signature of physician / healthcare professional **Date Signed**

License #_____

_____

Address

_____ _____ _____

City **State** **Zip Code**

(_____)_____ (_____)_____

Telephone Number **Fax Number**

Applicants who do not qualify for Mobility / Paratransit service may be eligible for MTA Reduced Fare status on regular fixed-route services (Local Bus, Metro Subway, Light Rail). Please call 410-767-3441 for more information on the Reduced Fare program.

For more information about Mobility, call 410-764-8181 or Maryland Relay Service.

This application is available in alternate format upon request.

PLEASE MAIL APPLICATION TO:

MTA Mobility Certification Office
4201 Patterson Avenue, 2ND Floor
Baltimore, MD 21215
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